STATE OF DELAWARE
DIVISION OF MOTOR VEHICLES
APPLICATION FOR SPECIAL LICENSE PLATE OR SPECIAL PARKING ID PLACARD FOR PERSONS WITH DISABILITIES

FOR OFFICE USE ONLY

Parking ID Placard No:_____

Date Issued:_____

Expires:_____

FOR OFFICE USE ONLY

Special Parking Plate No:_____

Date Issued:_____

(DO NOT WRITE ABOVE THIS LINE)

APPLICANT: COMPLETE THIS SECTION BEFORE PHYSICIAN CERTIFICATION

Applicant's Name:_____
(Please Type or Print)

Street Address:_____

City, State, Zip Code:_____

LONG TERM LICENSE PLATE OR PLACARD ONLY

INDIVIDUAL MUST BE OWNER OF VEHICLE OR HOUSEHOLD MEMBER TO QUALIFY FOR A SPECIAL LICENSE PLATE (COMPLETE BELOW)

Tag Number:_____

Make & Year of Vehicle:_____

Expiration Date:_____

Serial Number:_____

Driver's License Number:_____

Gross Weight of Vehicle:_____
(14,000 lb. limit)

NOTE: A new application must be completed and signed by your physician prior to renewing your vehicle registration.

COMPLETE THIS SECTION IF APPLYING FOR A SPECIAL PARKING ID PLACARD

NEW ☐ **RENEWAL** ☐ **REPLACEMENT** ☐

I am applying for a special parking ID placard. I understand that **it must be displayed on the rearview mirror of the vehicle whenever such vehicle is parked in a disabled parking space. This placard must be removed when the vehicle is in motion.** I also understand that the placard expires in three (3) years and must be renewed

NOTE: A new application must be completed and signed by your physician prior to renewing your placard.

*****NOTE: INDIVIDUALS WHO ARE 85 YEARS OF AGE OR OLDER ONLY NEED TO SHOW PROOF OF AGE TO OBTAIN A SPECIAL PLACARD. DATE OF BIRTH:_____**

THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR PHYSICIAN:

Eligibility, by law, for a long-term plate or placard is restricted to permanent disabilities with no prognosis for improvement. (NO OTHER PERSON IS ELIGIBLE FOR A LICENSE PLATE OR PLACARD) A physician must certify this application. Applicant must meet one of the following requirements with **no prognosis for improvement**:

☐ 1. Cannot walk 200 feet without stopping to rest.

☐ 2. Cannot walk safely without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistive device.

☐ 3. Is restricted by lung disease to such an extent that the applicant's or household member's forced (respiratory) expiratory volume, one second, when measured by spirometry, is less than one liter or the arterial oxygen tension is less than sixty mm/hg. at room air or rest.

☐ 4. Uses portable oxygen.

☐ 5. Has a cardiac condition to the extent that the applicant's or household member's functional limitations are classified in severity as Class III or Class IV according to the standards set by the American Heart Association.

☐ 6. Is severely limited in his or her ability to walk due to an arthritic, neurological or orthopedic condition.

TEMPORARY PLACARD ONLY

NEW ☐ RENEWAL ☐ REPLACEMENT ☐

I am applying for a temporary special parking ID placard. I understand it must be displayed on the rearview mirror of the vehicle whenever such vehicle is parked in a disabled parking space. This placard must be removed when the vehicle is in motion. I also understand that the placard has an expiration date and may be renewed. **NOTE: A new application must be completed and signed by your physician prior to renewing your placard.**

Eligibility, by law, for a temporary special parking ID placard is restricted to a physical disability that is not permanent, but that substantially limits or impairs the applicant's or household member's ability to walk for **not less than five (5) weeks**, and which is so severe that the person would endure a hardship or be subject to a risk of injury without a temporary special ID placard. (NO OTHER PERSON IS ELIGIBLE FOR A SPECIAL PARKING ID PLACARD.) ***THE TEMPORARY SPECIAL PARKING ID PLACARD ISSUED TO THE APPLICANT IS LIMITED TO _____ DAYS (MINIMUM 35 DAYS/MAXIMUM 90 DAYS.)***

*****PHYSICIAN MUST PROVIDE HIS OR HER CERTIFICATION BELOW.**
I certify, under penalty of law, that the above information concerning the applicant is true and correct, and that the applicant or household member meets the requirements specified above for the long-term special license plate/parking ID placard or temporary special parking ID placard.

Date:_____ Signature of Physician:_____

PRINT NAME, ADDRESS AND TELEPHONE NUMBER OF LICENSED PHYSICIAN:

_____(Physician's Name) _____
(Verification Telephone Number)

_____(Street Address or P.O. Box)

_____(City, State and Zip) _____
(Verification Contact Name)

I certify, under penalty of law, that the above information is true and correct. I also understand that false representation by me can lead to penalties as provided by law as follows: Any person who is not disabled, as defined above, and who intentionally and falsely represents that such person has the qualifications to obtain such a special license plate or parking ID placard in an attempt to obtain such plate or placard shall for the first offense be fined $100. For each subsequent like offense, the person shall be fined $200, or imprisoned not less than 10 nor more than 30 days, or both.

NOTE: I understand the special license plate and/or parking ID placard must be returned when no longer needed.

Signature of Applicant:_____ Date:_____

Approved:_____
Name of DMV Specialist